Department of Veterans Affairs
Office of Inspector General
April 2015 Highlights

CONGRESSIONAL TESTIMONY

Assistant Inspector General Testifies Before House Committee on Veterans' Affairs on Mismanagement and Data Manipulation at the Philadelphia and Oakland VA Regional Offices

Linda A. Halliday, Assistant Inspector General (AIG) for Audits and Evaluations, testified before the Committee on Veterans' Affairs, United States House of Representatives, on the results of the Office of Inspector General's (OIG) recently published reports that substantiated allegations of mismanagement and data manipulation at the Philadelphia, Pennsylvania, VA Regional Office (VARO) and allegations of claims mismanagement at the Oakland, California, VARO. Ms. Halliday told the Committee that OIG identified serious issues at the Philadelphia VARO involving mismanagement, and that OIG made 35 recommendations for improvement encompassing operational activities relating to data integrity, public contact, financial stewardship, mail mismanagement, and other areas of concern. Ms. Halliday also stated that Oakland VARO staff had not processed a significant number of informal requests for benefits found in October 2012 that dated back as far as July 2002 and improperly stored formal claims. Furthermore, management's poor recordkeeping practices precluded OIG from confirming that VARO staff processed all of the informal claims or if the initial list contained 13,184 informal claims. Ms. Halliday was accompanied by Ms. Nora Stokes, Director, OIG Bay Pines Benefits Inspection Division and Mr. Brent Arronte, Director, OIG San Diego Benefits Inspection Division. [Click here to access testimony.]

OIG's Top Physician Tells Senate Veterans' Affairs Committee VHA Must Make Quality Health Care Its Most Important Mission

Dr. John D. Daigh, Jr., AIG for Healthcare Inspections, accompanied by Mr. Gary K. Abe, Deputy AIG for Audits and Evaluations, testified before the Committee on Veterans' Affairs, United States Senate, to discuss OIG's health care reviews and audits of programs and performance of the Veterans' Health Administration (VHA). Dr. Daigh testified that VHA is at risk of not performing its chief mission to deliver high quality health care as the result of several intersecting factors: 1) VHA has several missions, and too often management decisions compromise the most important mission of providing veterans with quality health care; 2) leadership has too often compromised national VHA standards to meet short term goals; 3) the Veterans Integrated Service Networks (VISN) do not consistently support local VA Medical Centers to encourage success and proactively address areas of risk; 4) resource management data gaps make the cost-effective delivery of a national benefit challenging, and 5) VHA's internal processes are inefficient and make the conduct of routine business unnecessarily burdensome. Dr. Daigh reported that the issues confronting VHA are issues that OIG has long reported as serious and in need of attention at the VA Central Office, at the VISN, and at the facility levels, and that OIG will continue to do so until we see that lasting change has occurred. [Click here to access testimony.]

ADMINISTRATIVE INVESTIGATIONS

OIG Criticizes Office of Information and Technology Officials' Response to Improper Access of VA Network by Contractors While Working in China and India

Seven years after the 2006 data breach, VA information security employees still reacted with indifference, little sense of urgency, or responsibility concerning a possible cyber threat incident. Austin Information Technology Center (AITC) Office of Information and Technology (OIT) employees failed to follow VA information security policy and contract security requirements when they approved VA contractor employees to work remotely and access VA's network from China and India. One accessed it from China using personally-owned equipment (POE) that he took to and left in China, and the other accessed it from India using POE that he took with him to India and then brought back to the United States. After the Acting Chief Information Officer (CIO) learned of this improper remote access, he gave verbal instructions for it to cease; however, VA information security employees at all levels failed to quickly respond to stop the practice and to determine if there was a compromise to any VA data as a result of VA's network being accessed internationally. Further, OIG found that a VA employee, as well as other VA contractor employees, improperly connected to VA's network from foreign locations. [Click here to access report.]

OIG REPORTS

Patient-Centered Community Care Contracts Cost VA $14.9 Million More Than if VA Used Non-VA Care Program To Purchase Same Health Care Services

In April 2014, OIG received a request from the U.S. House of Representatives Committee on Appropriations to review VA's Fiscal Year (FY) 2014 Patient-Centered Community Care (PC3) costs and the $13 million cost savings estimate presented in VA's budget submission. OIG could not attest to the reliability and accuracy of VA information regarding the methodology and calculation of the PC3 cost savings estimate. Our analysis of available PC3 data determined that inadequate price analysis, high up-front contract implementation fees, and low PC3 utilization rates impeded VA from achieving its $13 million PC3 cost saving estimate. OIG found that in FY 2014 PC3 cost about $14.9 million more than if VA had used the non-VA care program to purchase the same health care services. VA assumed that the PC3 contractors would develop adequate provider networks; VA medical facilities would achieve desired 25 to 50 percent contract utilization rates; and accrued PC3 cost savings for health care services would more than offset the contractors' fees. These flawed assumptions contributed to significant PC3 contract performance problems and a 9 percent PC3 utilization rate in FY 2014. OIG recommended the Interim Under Secretary for Health revise VA's PC3 cost analyses and address VA's low PC3 utilization rates. Additionally, OIG recommended the Executive Director, Office of Acquisition, Logistics, and Construction, ensure all required contract documents are maintained in the PC3 contract files. [Click here to access report.]

OIG Makes Nine Recommendations To Improve Access to Care and Completeness of Medical Records at VA Maryland Health Care System

OIG conducted a review in response to concerns raised by Senator Barbara Mikulski regarding lapses in access and quality of care issues at the VA Maryland Health Care System. The purpose of this review was to determine the extent to which those concerns had merit. OIG substantiated delayed access for a patient at the Perry Point campus and identified some contributing factors, including insufficient primary care provider staffing. OIG substantiated that the system experienced challenges in providing timely access to orthopedic surgical services but had developed an action plan to address these issues prior to our visit. OIG did not substantiate concerns that a second patient experienced delays in service delivery or cancer diagnosis at the urgent care center at Perry Point. OIG also did not substantiate allegations related to a third patient's diabetes and diabetic neuropathy pain; however, OIG found that community health care information was not included in the patient's electronic health record because of provider documentation lapses and, possibly, a backlog of documents waiting to be scanned. OIG further found that the system's policy for tube-feeding nutrition did not comply with all requirements. OIG made nine recommendations. [Click here to access report.]

OIG Recommends Better Controls on Date Stamping Equipment and Refresher Training at Boston, Massachusetts, VA Regional Office

OIG substantiated that a Veteran Services Officer (VSO), accredited and employed by the Veterans of Foreign Wars (VFW), Department of Massachusetts, manipulated or attempted to manipulate dates of claims at the Boston VA Regional Office (VARO). OIG also found evidence indicating the VSO may have engaged in a similar manipulation scheme at the VARO in Togus, Maine. The VSO secretly date stamped multiple blank documents, providing the opportunity to cut, attach, and photocopy these dates onto claims documents for other claimants. Manipulation of dates of claims appeared to be a routine practice dating back to at least July 2013. OIG found about 25 benefits claims in the VSO's workspace that had not been submitted to the VARO for processing; some of the claims dated back to October 2013. OIG could not identify claims where the VSO may have altered the actual dates of claim because there is no audit trail that tracks claims submitted by individual VSOs. Untimely processing by the VSO impedes the VARO's ability to initiate required development actions and results in veterans waiting longer for their claim to be processed. The VSO was able to manipulate dates of claims to cover up the untimely submission of claims because VARO management did not ensure only authorized staff accessed and used its date stamping equipment. Additionally, VARO management did not ensure the keys needed to unlock and operate date stamping machines were securely stored. Rather, keys were stored in unlocked desk drawers near the date stamping machines. Further, manipulation of dates of claims compromised the data integrity of claims processing timeliness and introduced delays in processing benefits claims. OIG recommended the Under Secretary for Benefits implement plans to ensure only authorized staff at the Boston VARO use date stamping equipment and that they receive refresher training on securing date stamping equipment. [Click here to access report.]

OIG Finds Mismanagement and Distrust Impede Philadelphia, Pennsylvania, VARO Operational Effectiveness

In late May 2014, OIG began receiving a number of allegations through the VA OIG Hotline of mismanagement at the Philadelphia, PA, VARO. Many of these allegations included indicators that staff had a serious mistrust of VARO management. On June 19, 2014, OIG benefits inspectors, auditors, and criminal and administrative investigators began a comprehensive review of conditions at the Philadelphia VARO. Overall, OIG staff conducted over 100 interviews with VARO management and staff to assess the merits of multiple allegations of wrongdoing. OIG substantiated serious issues involving mismanagement and distrust of VARO management impeding the effectiveness of its operations and services to veterans. Overall, OIG made 35 recommendations for improvement at the Philadelphia VARO, encompassing mismanagement of VA resources resulting in compromised data integrity, lack of financial stewardship, and lack of confidence in management's ability to effectively manage workload, to include mail management and in protecting documents containing personally identifiable information. There is an immediate need to improve the operation and management of this VARO and take actions to ensure a more effective work environment. Further, the extent to which management oversight has been determined to be ineffective and/or lacking requires Veterans Benefits Administration's (VBA) oversight and action. It is imperative to ensure VBA leadership and the VARO Director implement plans to ensure the unprocessed workload OIG identified is processed and to provide appropriate oversight that is critical to minimizing the potential future financial risk of making inaccurate benefit payments. This includes maintaining oversight needed to ensure all future workload is processed timely and in ensuring the accurate and timely delivery of benefits and services. [Click here to access report.]

Delays at Memphis, Tennessee, VA Emergency Department Deemed Unavoidable Given Patient Population, Progress Noted Since Last Review

OIG conducted an inspection in response to complaints about the timeliness and quality of care in the Emergency Department (ED) and Primary Care of the Memphis VA Medical Center (facility), Memphis, TN, which is part of Veterans Integrated Service Network (VISN) 9. OIG did not substantiate the allegation that Memphis ED personnel were inattentive and failed to provide timely care. The patient was triaged appropriately on arrival. The 4-hour delay the patient experienced before leaving without being seen by an ED provider was unfortunate yet unavoidable due to the patient population in the ED at the time of the patient's visit. OIG did not substantiate the allegation that Primary Care provider assistants were inattentive to the patient's requests for medical help via phone and VA's electronic secure messaging system. Primary Care clinic staff responded to the patient's requests, and the patient received the services he requested. While OIG found occasional delays in responding to the patient's requests, overall, delays were not typical. OIG substantiated the allegation that VA refused to pay for private facility care; however, this decision was based on Federal regulations. OIG substantiated the allegation that the facility faxed incorrect records to the ED of a private hospital. This was attributed to human error by a staff member at the facility, and as a result, the facility changed its process for providing medical information to other hospitals. OIG found that the new process was being followed at the time of our visit;

therefore, OIG made no recommendation. OIG did not substantiate the allegation that the facility ignored recommendations or postponed implementation of actions recommended by the OIG in previous reports. OIG made no recommendations. [Click here to access report.]

OIG Recommends Strengthening Teleradiology Oversight at Central Arkansas Veterans Healthcare System, Little Rock, Arkansas

OIG reviewed the Central Arkansas Veterans Healthcare System (CAVHS) Teleradiology Reading Center (TRC) to determine the merits of an allegation that radiologists stopped reading exams for CAVHS patients when they had reached their minimum Relative Value Unit (RVU) level and then performed fee-basis interpretations for other VA facilities during their tours of duty under a TRC agreement. OIG did not substantiate the allegation that CAVHS radiologists inappropriately performed fee-basis interpretations for other VISN 16 medical facilities during their scheduled duty hours. Our review of 7,657 interpretations between January 1, 2014, and June 30, 2014, determined that CAVHS radiologists conducted their TRC interpretations during non-duty hours. OIG did not find that radiologists stopped performing radiology interpretations for CAVHS patients when they had reached their minimum production level. However, OIG found VISN 16 could improve their controls to add more reliability to their determinations that radiologists performed TRC interpretations during non-duty hours. Of 7,657 interpretations, OIG identified 384 interpretations that appeared radiologists started or accessed during duty hours. OIG used data not accessed by VISN staff and identified the actual time radiologists dictated their interpretation. OIG determined radiologists made all 384 interpretations during non-duty hours. OIG also found that CAVHS radiologists' timecards did not accurately show their official weekend tour of duty and VISN 16 had not reviewed the TRC agreement in the past 5 years. OIG recommended the Interim VISN 16 Director review the time interpretations started and ended to ensure radiologists perform TRC interpretations during their non-duty hours, establish policy on an official tour of duty for weekend duty, and require annual certification of the TRC agreement. [Click here to access report.]

Combined Assessment Program Reviews

In April 2015, OIG published six Combined Assessment Program (CAP) reviews containing OIG findings for the facilities listed below. The purpose of the CAP reviews was to evaluate selected health care facility operations. Topics reviewed may vary due to differences in services provided at each facility, the need to follow up on previous CAP findings, or the rotation of CAP review topics over time. The reviews covered the following nine activities: (1) Quality Management, (2) Medication Management, (3) Coordination of Care, (4) Magnetic Resonance Imaging Safety, (5) Acute Ischemic Stroke Care, (6) Mental Health Residential Rehabilitation Treatment Program, (7) Emergency Airway Management, (8) Environment of Care, and (9) Surgical Complexity.

VA Puget Sound Health Care System, Seattle, Washington
Dayton VA Medical Center, Dayton, Ohio
Martinsburg VA Medical Center, Martinsburg, West Virginia

Veterans Health Care System of the Ozarks, Fayetteville, Arkansas
CAP Summary - Evaluation of Quality Management in VHA Facilities FY 2014
VA Palo Alto Health Care System, Palo Alto, California

Community Based Outpatient Clinic Reviews
In April 2015, OIG published three Community Based Outpatient Clinic (CBOC) reviews containing OIG's findings at select CBOCs and primary care clinics that fall under the oversight of the parent facilities listed below. The purpose of the CBOC reviews was to evaluate four operational activities: (1) Environment of Care, (2) Alcohol Use Disorder, (3) Human Immunodeficiency Virus Screening, and (4) Outpatient Documentation.

Veterans Health Care System of the Ozarks, Fayetteville, Arkansas
VA St. Louis Health Care System, St. Louis, Missouri
Ralph H. Johnson VA Medical Center, Charleston, South Carolina

ADMINISTRATIVE CLOSURES
As a result of a review of OIG decision-making practices on closing reviews administratively, the Deputy Inspector General instituted a new policy requiring coordination of administrative closures within the Immediate Office of the Inspector General, the Office of the Counselor to the Inspector General, and the Release of Information Office. This process will ensure consistency in decision-making regarding when and how public release of related documents is handled. The Deputy Inspector General also directed a retrospective review of administrative closures by the Office of Healthcare Inspections from FY 2006 to present. Based on this review, OIG has published administrative closure reports on the OIG website, publishing 115 in April. Please review Table 1 at the end of this report for a full list of Administrative Closures published in April 2015.

CRIMINAL INVESTIGATIONS
Former VA Fiduciaries Indicted for Misappropriation by a Fiduciary
A former VA appointed fiduciary, who was also an administrator of a nursing home, was indicted for misappropriation by a fiduciary. An OIG investigation determined that the defendant embezzled more than $313,000 from a veteran's benefit payments. A second former VA fiduciary was indicted for theft of Government funds. An OIG investigation determined that the defendant stole $69,686 in VA funds intended for a veteran and used the money for personal expenses.

Contract Employee Pleads Guilty to Mail Fraud
A former employee of a VA Home Based Primary Care contractor pled guilty to mail fraud. An OIG and U.S. Secret Service investigation revealed that the employee stole approximately $75,000 from an 87-year-old blind veteran beneficiary for whom she was entrusted to care and pay bills. The defendant wrote checks to herself and forged the veteran's signature with his signature stamp. The defendant purchased a motorcycle and a sports utility vehicle with the stolen funds, both of which were seized during the investigation. The defendant also admitted to gambling a significant portion of the money away.

Veterans Sentenced for "Stolen Valor"
A veteran was sentenced to 6 months' incarceration, 2 years' supervised release, and ordered to pay VA $174,656 in restitution after pleading guilty to theft of public money. An OIG investigation revealed that the defendant fraudulently received VA compensation benefits based on an altered DD-214 that he falsified in 1970 by claiming multiple combat awards, including two Purple Hearts and a Silver Star. Approximately 30 years later, the defendant submitted a fraudulent application to VA seeking compensation for post-traumatic stress disorder and shell fragment wounds. The defendant claimed to have participated in hand-to-hand combat and sustained bayonet wounds, a gunshot wound, and shrapnel wounds. The defendant claimed on VA forms and in discussions with VA physicians that he had survived these battle wounds and that he had killed numerous enemy combatants. Through a review of records, witness interviews, and the defendant's own admissions, the investigation determined that the defendant did not receive any combat awards and did not suffer any combat injuries while in Vietnam. Also, the investigation determined that his scars were actually caused by minor cosmetic surgery. A second veteran was sentenced to 2 years' probation and ordered to pay $101,367 in restitution after pleading guilty to falsely altering a certificate of discharge from the U.S. Navy. An OIG investigation revealed that the veteran altered his DD-214 to indicate he received a Purple Heart as well as a Vietnam Gallantry Cross in order to qualify for benefits. A copy of the veteran's service record did not list any of the awards claimed and indicates the veteran never deployed to Vietnam.

Veteran Indicted for VA Compensation Fraud
A veteran was indicted and arrested for wire fraud after an OIG and Federal Bureau of Investigations (FBI) investigation revealed he misrepresented the extent and severity of his disabilities in order to obtain VA benefits, including funds for the installation of a swimming pool and purchase of an automobile. From 1995 to 2015 the veteran falsely represented to VA that he had significant loss of vision, requiring the use of aids for the blind or visually impaired. The defendant was observed driving a vehicle at the VA Medical Center (VAMC) and in the community, as well as performing other daily activities that required better vision than claimed. The loss to VA is approximately $800,000.

Veteran Pleads Guilty To Making False Statements to VA
A veteran pled guilty to making false statements after an OIG investigation revealed that since 1999 he claimed that he was 100 percent disabled for blindness. However, the defendant was observed driving his registered vehicle (including to his Compensation and Pension exam) and navigating in public without assistance or use of a cane after he claimed to VA that he could do neither. The loss to VA is $344,700.

Medical Device Company Former Chief Executive Officer and Vice President of Sales Indicted on Multiple Charges
The former chief executive officer and vice president of sales of Acclarent, Inc., a medical device company, were indicted for conspiracy, securities fraud, wire fraud, and violations of the Food, Drug, and Cosmetic Act. An OIG, FBI, Defense Criminal Investigative Service, and Food and Drug Administration (FDA) investigation revealed

that the two defendants engaged in a scheme to fraudulently drive up Acclarent, Inc., revenues and stock valuation by illegally marketing a medical device known as the Relieva Stratus Microflow Spacer ("Stratus") for uses not approved by FDA. Despite the fact that the company had told the FDA that the Stratus was a medical device intended to maintain an opening to the patient's sinus, the defendants launched the product intending it to be used as a steroid delivery device. VA purchased products from Acclarent, Inc., including the Stratus.

Northampton, Massachusetts, VAMC Nursing Assistant Charged with Assaulting Disabled Veteran

A Northampton, MA, VAMC nursing assistant was charged with assaulting an elderly disabled veteran. An OIG and VA Police Service investigation revealed that the defendant forcefully took the veteran to the ground during a psychiatric intervention causing injury. The defendant continued to verbally and physically assault the veteran after the patient had been taken to his room.

Anesthesiologist Pleads Guilty to Theft of Government Property and Simple Possession

A University of California, Los Angeles (UCLA), anesthesiologist pled guilty to theft of Government property and simple possession of a controlled substance. A multi-agency investigation revealed that while completing a rotation at the West Los Angeles, CA, VAMC and providing anesthesia care to a veteran in surgery, the defendant collapsed due to sublingual ingestion of clonazepam and injection of multiple controlled substances.

Veteran Arrested for Making Threats to VA Employee at White River Junction VAMC

A veteran was arrested for making threats to a VA employee. An OIG and VA Police Service investigation revealed that the veteran was seeking a certain procedure in a non-VA facility located in Florida, although the veteran was a resident of Vermont. VA did not find the veteran eligible for such a procedure. After the veteran learned that the White River Junction, VT, VAMC denied the consult for the non-VA care, the veteran threatened the chief of staff. When the veteran's primary care physician asked the veteran if he was planning on harming anyone, the veteran said he was planning on getting a burial plot that same day and was making arrangements for his children to be cared for by his brother in Texas. The veteran also told his VA physician, "I will not hurt myself alone and I'm not going out alone!" Specific conditions of the veteran's release included home detention with a location monitoring bracelet and no contact with VA staff or property except through the VA Police Service and the emergency room.

Non-Veteran Pleads Guilty to Possession of Unauthorized Access Devices and Aggravated Identity Theft

A non-veteran pled guilty to possession of unauthorized access devices and aggravated identity theft. An OIG, Internal Revenue Service Task Force, and FBI investigation revealed that the defendant stole veterans' and military service members' identities that he obtained while overseeing VA education benefits at Kaplan University. During the

investigation, law enforcement purchased or seized approximately 378 identities of veterans who had either attended or applied to Kaplan University.

Non-Veteran and Two Veterans Plead Guilty To Conspiring To Defraud VA of Education Benefits
A non-veteran and two veterans pled guilty to conspiring to defraud VA. The non-veteran operated a barber school and created false documents to indicate veterans were attending class and taking tests. The veterans would contact VA each month and falsely claim to be attending the barber school in order to receive VA education benefits. The non-veteran ensured he received a portion of the monthly education benefit by contacting VA and reporting veterans for non-attendance if they failed to pay him. Additional charges are expected involving 13 additional veterans who also received VA education benefits to attend the school. The loss to VA is approximately $139,000.

Veteran Sentenced for VA Compensation Fraud
A veteran was sentenced to 84 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $811,592. A VA OIG and Social Security Administration (SSA) OIG investigation revealed that since 1999 the defendant received Individual Unemployability (IU) benefits while working as a pastor, mortgage broker, car salesman, and golf professional. The defendant worked under other individuals' identities in order to conceal his work history from VA and SSA. The loss to VA is $365,000.

Veteran Arrested for Theft of Government Funds
A veteran was arrested for theft of Government funds. A VA OIG and Department of Transportation OIG investigation revealed that the defendant applied for and received IU benefits while he was employed full-time by the Federal Aviation Administration. The loss to VA is over $97,000.

Veteran and Spouse Indicted for VA Pension Fraud
A veteran and his spouse were indicted for conspiracy to commit theft of Government funds and theft of Government funds after concealing their income in order to receive $197,784 in VA pension benefits. An OIG investigation revealed that beginning in 2003 the defendants concealed the spouse's annual salary of over $50,000.

Veteran Arrested for Theft of Government Funds
A veteran was arrested for theft of Government funds after an OIG investigation revealed that she failed to report her income from 2010 to 2014. During that time, the defendant worked at various internet gaming casinos and as a housekeeper, in addition to having received child support payments. The loss to VA is approximately $45,000.

Daughter of Deceased VA Beneficiary Indicted for Theft of Government Funds
The daughter of a deceased Dependency and Indemnity Compensation beneficiary was indicted for theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after her mother's death in January 1998. The loss to VA is approximately $194,000.

Daughter of a Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds
The daughter of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant failed to report her mother's death to VA and subsequently stole VA benefits that were direct deposited after her mother's death in July 2005. The loss to VA is $133,924.

Daughter of Deceased VA Beneficiary Indicted for Theft of Government Funds and False Statements
The daughter of a deceased beneficiary was indicted for theft of Government funds and false statements in a bankruptcy matter. An OIG investigation revealed that the defendant failed to report her mother's death to VA in February 2008. The mother was removed from the bank account, and the defendant, along with the estate's executor who died in 2013, became the sole owners of the account. The defendant then stole the VA benefits that were direct deposited. Also, in 2014 the defendant concealed the stolen funds on her bankruptcy application and in her testimony during a bankruptcy hearing. The loss to VA is $90,006.

Veterans Sentenced for "Doctor Shopping"
A total of 22 cases were adjudicated against veterans who were indicted for obtaining prescription medication by fraud, deceit, or subterfuge, and theft of Government property. Twenty of the veterans entered the Pretrial Diversion Program, one veteran was sentenced to 1 year of probation, and the remaining veteran received a time served sentence. The sentences were the result of an OIG investigation that revealed that the veterans were simultaneously obtaining controlled medication from the Greenville, SC CBOC and outside sources.

Former U.S. Postal Service Employee and Spouse Indicted for Theft of VA Drugs
A former U.S. Postal Service (USPS) employee and his spouse were indicted and arrested for conspiracy to possess stolen U.S. mail, theft of VA mail packages, and conspiracy to possess hydrocodone to distribute. An OIG and U.S. Postal Inspection Service investigation determined that the defendants diverted approximately 552 VA drug packages from the USPS Hub in Memphis, TN. The packages were destined for the Jackson, MS, area but were redirected to Alabama by the defendant for distribution and resale. The loss to VA is $22,342.

Non-Veteran Arrested for Criminal Possession of a Controlled Substance
A non-veteran was arrested for criminal possession of a controlled substance. An OIG, VA Police Service, and Ontario County Sheriff's Office investigation revealed that the defendant intended to sell drugs to a veteran who was going through addiction counseling at the Canandaigua, NY, VAMC.

Richard J. Griffin
Deputy Inspector General

Table 1

Administrative Closures (April 2015)	
Report Number	**Title**
05-01370-332	Delay in Evaluation and Treatment of Pulmonary Metastasis from Malignant Melanoma, VA Illiana Health Care System, Danville, IL, Richard L. Roudebush VAMC, Indianapolis, IN, and Iowa City VA Health Care System, Iowa City, IA
05-02815-223	Insufficient Staffing and Mismanagement Issues, Jesse Brown VA Medical Center, Chicago, IL
05-03285-225	Alleged Practice Inconsistencies, West Palm Beach VA Medical Center, West Palm Beach, FL
05-03445-324	Alleged Hiring Misconduct, Central Texas Veterans Health Care System, Temple, Texas
06-00690-280	Delay in Neurosurgery Care, Bronx VA Medical Center, Bronx, New York
06-01144-315	Alleged Compromised Quality of Care and Alleged Poor/Falsified Documentation, Lebanon VA Medical Center, Lebanon, PA
06-01214-310	Patient Treatment Issues, Bay Pines VA Medical Center, Bay Pines, FL
06-01390-322	Alleged Implanted Defective Stent-Graft Devices, Pittsburgh VA Medical Center, Pittsburgh, Pennsylvania
06-01512-224	Alleged Misdiagnosis, VA San Diego Healthcare System, San Diego, California
06-01538-257	Alleged Quality of Care Concerns, Southern Arizona VA Health Care System, Tucson, Arizona
06-01587-321	Alleged Quality of Care Issues, Fargo VA Medical Center, Fargo, North Dakota
06-01671-222	Quality of Care Issues, Bay Pines VA Medical Center, Bay Pines, FL
06-01764-323	Inadequate Supervision of Patients and Failure to Report Incidents at the Northern Arizona VA Health Care System, Prescott, Arizona
06-02774-333	Alleged Patient Abuse, VA Maryland Healthcare System, Baltimore, MD
06-02927-314	Compromised Patient Safety and Privacy at the New Mexico VA Health Care System, Albuquerque, New Mexico
06-03056-221	Administrative Investigative Board, Atlanta VA Medical Center, Atlanta, Georgia
06-03398-259	Alleged Insufficient Staffing, Employee Health, and Patient Safety Issues, Marion VA Medical Center, Marion, Indiana
06-03685-331	Hospital Acquired Legionella Infection, Samuel S. Stratton VA Medical Center, Albany, New York
06-03705-256	Alleged Physician Credentialing Violation and Inadequate Physician Supervision, VA Connecticut Healthcare System, West Haven, Connecticut
07-00645-243	Staffing Issues in Anesthesiology, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina
07-01041-255	Suspicious Death, VA Connecticut Healthcare System, West Haven, Connecticut

07-01494-281	Patient Safety Issues, Hampton VA Medical Center, Hampton, Virginia
07-01893-282	Alleged Quality of Care Issues, Martinsburg VA Medical Center, Martinsburg, West Virginia
07-01995-258	Alleged Inappropriate Treatment, VA Puget Sound Health Care System, Seattle, Washington
08-00411-279	Alleged Credentialing and Privileging Irregularities and Background Issues at the VA Illiana Health Care System, Danville, IL
08-00725-283	Non-Profit Research Corporation and Physician Time and Attendance Issues, Atlanta VA Medical Center, Atlanta, Georgia
08-00777-326	Alleged Quality of Care Concerns, Fayetteville VA Medical Center, Fayetteville, North Carolina
08-01325-312	Hiring Practices and Surgical Service Issues, VA Illiana Health Care System, Danville, Illinois
08-01333-329	MRI Timeliness Involving VA Boston Healthcare System, Boston, Massachusetts and Togus VA Medical Center, Augusta, Maine
08-01399-334	Alleged Denial of Extended Care Services, VA Maryland Health Care System, Baltimore, Maryland
08-01704-246	Alleged Unsanitary Environment, San Bernardino Vet Center, San Bernardino, California
08-01865-244	Quality of Care at the Michael E. DeBakey VA Medical Center, Houston, TX
08-02841-245	Allegations of Abuse of Controlled Substances Prescriptive Authority, James A. Haley VA Medical Center, Tampa, FL
08-02868-276	Quality of Care and Discharge Planning Issues, Martinsburg VA Medical Center, Martinsburg, West Virginia
09-00068-328	Quality of Care Issues, Tennessee Valley Healthcare System, Murfreesboro, Tennessee
09-00313-273	Allegation of a Physician Overmedicating Mental Health Patients, Malcolm Randall VAMC, NF/SGVHA (Valdosta CBOC)
09-00717-277	Alleged Research Program Improprieties, VA Central Iowa Health Care System, Des Moines, Iowa
09-00775-330	Alleged Insufficient Staffing Issues at the Alaska VA Healthcare System and Regional Office, Alaska VA Healthcare System, Anchorage, Alaska
09-01813-278	Alleged Quality of Care Issues, New Jersey Healthcare System, Lyons Campus, East Orange, New Jersey
09-01858-233	Alleged Quality of Care Issues at the Rhode Island State Veterans Home, Providence, Rhode Island
09-02066-274	Alleged Patient Care and Contracting Issues at the Loch Raven Community Living Center, VA Maryland Health Care System, Baltimore MD
09-02208-327	Quality of Care Concerns, VA Western New York Healthcare System, Buffalo, New York
09-02508-325	Allegations that Retaliation Led to a Reduction in the Level of Care and that Patient Safety was Jeopardized, James A. Haley Veteran's Hospital, Tampa, Florida

09-02826-271	Legionnaire's Disease-Related Testing, VA Pittsburgh Health Care System, Pittsburgh, Pennsylvania
09-03665-232	Alleged Cardiology and Administrative Issues, Phoenix VA Health Care System, Phoenix, Arizona
10-00126-230	Lack of Cardiology and Vascular Services, Manchester VA Medical Center, Manchester, NH
10-00348-270	Delay of Inter-Facility Transfer, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin
10-00369-261	Alleged Failure to Diagnose Renal Cancer, Charles George VA Medical Center, Asheville, North Carolina
10-00480-313	Delay in Diagnosis, Lexington VA Medical Center, Lexington, KY
10-00689-231	Physician Privileging Issues, Marion VA Medical Center, Marion, Illinois
10-01107-272	Alleged Conflict of Interest, Marion VA Medical Center, Marion, Illinois
10-01388-275	Waiting Times for Mental Health Clinic Appointments, Atlanta VA Medical Center, Atlanta, Georgia
10-02443-264	Review of Oral Cancer Diagnosis, Birmingham VA Medical Center, Birmingham, AL
10-02487-235	Alleged Patient Confidentiality, CBOC Staffing and Clinic Workload Issues, Ashtabula Community Based Outpatient Clinic, Ashtabula, Ohio
10-02852-260	Misuse of Intergovernmental Personnel Act (IPA) Appointments to Pay Administrative Salaries at the East Bay Institute for Research and Education (EBIRE), Martinez, California
10-03221-265	Out-of-Operating Room Airway Management, Central Arkansas VA Health Care System, North Little Rock, Arkansas
10-03276-267	Review of Selected Surgical Services, Phoenix VA Health Care System, Phoenix, Arizona
10-03463-263	Improper Handling of Laboratory Specimens at the VA Gulf Coast Health Care System, Biloxi, Mississippi
10-03888-240	Alleged Mold Issues Impacting Employee and Patient Safety at the Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin
10-03929-337	Review of Alleged Discharge Planning Issues, Robley Rex VA Medical Center, Louisville, Kentucky
11-00014-317	Opioid Use Policies at the Miles City and Glendive Community Based Outpatient Clinics, VA Montana Healthcare System, Fort Harrison, MT
11-00037-268	Delay of Diabetes Mellitus Diagnosis, VA Maryland Health Care System, Perry Point, Maryland
11-00057-238	Time and Attendance Issues, John D. Dingell VA Medical Center, Detroit, MI
11-00235-269	Alleged Quality of Care Issues, Robley Rex VA Medical Center, Louisville, Kentucky
11-00374-239	Alleged Emergency Department Safety Issues, Durham VA Medical Center, Durham, North Carolina
11-00446-234	Review of Tucson VA Medical Center, Anthem CBOC, and Phoenix VA Medical Center, Arizona
11-00530-262	Alleged Quality of Care Issues, Bay Pines VA Healthcare System, Bay

	Pines, Florida
11-01025-242	Review of Alleged Quality of Care Issues, Manhattan Campus of the VA New York Harbor Health Care System, New York, New York
11-01057-241	Patient Neglect in the Community Living Center, Hunter Holmes McGuire VA Medical Center, Richmond, Virginia
11-01082-237	Alleged Quality of Care Concerns, Anesthesia Section, Dayton VA Medical Center, Dayton, Ohio
11-01499-236	Alleged Delay in Diagnosis and Treatment of Cervical Cancer, VA North Texas Health Care System, Dallas, Texas
11-01519-251	Alleged Quality of Care Issues, VA Black Hills Health Care System, Fort Meade, SD
11-01978-247	Alleged Medical/Surgical Unit Staffing Deficiencies, Charles George Veterans Affairs Medical Center, Asheville, North Carolina
11-02538-318	Clinical and Administrative Issues in the Residential Treatment Programs, Carl Vinson VA Medical Center, Dublin, Georgia
11-02865-316	Increased Surgical Mortality and Falsification of Documents, Louis Stokes VA Medical Center, Cleveland, Ohio
11-03033-284	Alleged Fraudulent Computerized CPRS Documentation, Saginaw VA Medical Center, Saginaw, Michigan
11-03136-266	Alleged Dental Service Issues at Wilmington VA Medical Center, Wilmington, Delaware
11-04406-252	Alleged Quality of Care Issues, VA Montana Health Care System, Fort Harrison, Montana
12-00027-250	Quality of Care Issues at the Knoxville VA Outpatient Clinic, Knoxville, Tennessee
12-00206-290	Alleged Quality of Care Issues, Grand Junction VA Medical Center, Grand Junction, Colorado
12-00206-291	Alleged Quality of Care Issues, Grand Junction VA Medical Center, Grand Junction, Colorado
12-00206-320	Alleged Quality of Care Issues, Grand Junction VA Medical Center, Grand Junction, Colorado
12-00336-293	Alleged Quality of Care Issues, St. Cloud VA Health Care System, St. Cloud, Minnesota
12-00768-249	Adverse Outcomes after Minor Surgical Procedures, Central Alabama Veterans Health Care System, Montgomery and Tuskegee, AL
12-01236-254	Quality of Care and Credentialing Issues, VA North Texas Health Care System, Dallas, TX
12-01687-213	Alleged Research Irregularities, VA Western New York Health Care System, Buffalo, New York
12-02149-319	Alleged Safety Issues in the Surgical Intensive Care Unit, New Mexico VA Healthcare System, Albuquerque, New Mexico
12-02154-214	Alleged Mismanagement of Resources, VA Montana Health Care System, Fort Harrison, Montana
12-02180-289	Allegedly Working while Intoxicated, Manchester VA Medical Center, Manchester, NH

12-02378-294	Review of Alleged Quality of Care and Responsiveness Issues, Bay Pines VA Healthcare System, Bay Pines, Florida
12-02438-311	Misrepresentation of an Unlicensed Researcher as a Physician, Michael E. DeBakey VA Medical Center, Houston, Texas
12-02655-286	Alleged Quality of Care Concerns, Oklahoma City VA Medical Center, Oklahoma City, OK
12-02884-218	Quality of Care Issues, Spokane VA Medical Center, Spokane, Washington
12-03148-335	Scheduling Practice and Fee Basis Review, Central Texas Veterans Health Care System, Temple, TX
12-03247-298	Research Follow-Up and BSL-3 Issues, Office of Research Oversight, Washington, DC
12-03253-253	Pharmacy Wait Time and Supply Availability, VA North Texas Health Care System, Dallas, TX
12-03354-285	Alleged Poor Clinical Practice by an Otolaryngologist, Southeast Louisiana Veterans Health Care System, New Orleans, LA
12-03988-215	Teleretinal Imaging Program Review, VA Texas Valley Coastal Bend Health Care System, Harlingen, TX
12-04429-296	Review of Alleged Patient Abuse and Staff Issues, Tennessee Valley Healthcare System Alvin C. York Campus, Murfreesboro, Tennessee
12-04535-305	Alleged Violation of Ethical Standards, Tallahassee Outpatient Clinic, Tallahassee, FL
12-04621-309	Alleged Patient Safety Issues, The Villages Outpatient Clinic, The Villages, FL
13-00173-216	Home Oxygen Issues, Iowa City VA Health Care System, Iowa City, IA
13-00448-297	Alleged Quality of Care Issues, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois
13-00756-302	Review of Alleged Quality of Care Issues, Rochester Community Based Outpatient Clinic, Rochester, Minnesota
13-00902-301	Review of Delay in Treatment for Prostate Cancer, Phoenix VA Health Care System, Phoenix, Arizona
13-00945-303	Scope of Practice, Patient Abuse, and Medication Management in the Surgical Intensive Care Unit, VA Salt Lake City Health Care System, Salt Lake City, Utah
13-01208-217	Alleged Safety Issues in Mobile Health Clinics, Northport VA Medical Center, Northport, NY
13-01247-308	Alleged Quality of Care Issues, West Palm Beach VA Medical Center, West Palm Beach, FL
13-01685-304	Review of Care of a Dying Patient, South Texas Veterans Health Care System, San Antonio, Texas
13-01693-306	Review of Seattle Dermatology Quality of Care, VA Puget Sound Health Care System, Seattle, Washington
13-01759-300	Review of Alleged Surgeon Competency and Quality of Care Concerns, Oklahoma City VA Medical Center, Oklahoma City, Oklahoma
13-03001-295	Review of Mental Health Services Issues, El Paso VA Health Care System, El Paso, Texas

13-03137-307	Review of Failure to Recognize and Respond to a Patient in Crisis, South Texas Veterans Health Care System, San Antonio, Texas
13-03473-299	Community Living Center Patient Neglect/Abuse, Hunter Holmes McGuire VA Medical Center, Richmond, Virginia
14-03184-248	Cardiology Patient Care Delays, New Mexico VA Health Care System, Albuquerque, New Mexico